

Medicare: Helping Low-Income Seniors And People with Disabilities

Even though they have Medicare coverage, low-income seniors and people with disabilities can face unaffordable out-of-pocket health care costs due to Medicare's premiums, deductibles, co-insurance, copayments, and the Part D coverage gap or "doughnut hole." Many needy people with Medicare cannot qualify for additional assistance because of stringent asset or income limits, and they also cannot afford to purchase private supplemental coverage. Others could qualify for assistance but are not receiving it because of barriers to enrollment.

A key goal of health care reform is to ensure that health care is affordable for all Americans. Low-income people with Medicare should not be left behind to face increasingly unaffordable out-of-pocket costs. Moreover, as Congress considers making changes to Medicare financing as a way to pay for health care reform, it needs to make sure that help gets directly to those who need it the most.

Low-income Medicare beneficiaries can have substantial out-of-pocket costs

- The Part B (outpatient) premium is \$96.40/month, and it will increase in future years.
- The Part A (hospital) deductible is \$1,068, and those who are hospitalized more than once in the same year may have to pay this deductible again.
- Beneficiaries typically pay 20 percent co-insurance for most covered outpatient services.
- Beneficiaries faced an average Part D premium increase of 25 percent from 2008 to 2009.
- The Part D doughnut hole has grown to \$3,454 in uncovered drug costs in 2009.

Existing programs to help low-income beneficiaries are promising, but they suffer from low enrollment

- *No more than one-third of those who are eligible are enrolled in Medicare Savings Programs (MSPs), according to estimates. MSPs are a family of three programs that cover part or all of Part A and B premiums and cost-sharing.*
- *Well over 2 million seniors and people with disabilities remain eligible but are not enrolled in the Part D low-income subsidy (LIS), which covers Part D premium costs and most Part D cost-sharing, including the doughnut hole.*

Eliminate or substantially increase asset limits

- *Current rules penalize savings and leave many ineligible.*
- *Even with scheduled increases in 2010, asset limits for MSPs will be a bit over \$8,000 for an individual and \$13,000 for a couple. Partial prescription drug assistance is available under the Part D LIS for people with slightly more assets, but individuals with assets above about \$12,500 and couples above \$25,000 are disqualified from any help.*

- Asset limits should be eliminated for all of these programs, so that people who do the right thing and save during their working lives are not penalized. Eliminating asset limits will also simplify program administration.
- Alternatively, asset limits should be increased substantially to protect a reasonable amount of savings.

Align and increase income limits

- *Current income limits are confusing and too low.*
- MSP coverage is limited to people with incomes below 135 percent of the federal poverty level (\$1,281/month for an individual). The LIS provides partial coverage for those with incomes up to 150 percent of poverty (\$1,353/month for an individual), but full assistance is available only for those with incomes up to 135 percent.
- Income standards should be increased to provide greater assistance for Medicare beneficiaries with limited incomes who struggle with health care costs.
- Income eligibility rules should be aligned so that all programs use the same standards. This will make the programs easier to understand and administer.

Simplify and stabilize the programs

- *Simplification and stabilization of the programs would improve outreach and enrollment.*
- One of the MSPs, the Qualifying Individual (QI) program, should be made permanent or merged into other permanent programs to improve its stability.
- Elimination of burdensome application requirements such as annual recertification and income and asset documentation would increase enrollment.
- Careful use of federal databases to identify potentially eligible beneficiaries could lead to more targeted and effective outreach.
- Reducing the number of low-income beneficiaries forced to change Part D plans each year would improve continuity of care.

